

**BOARD OF REGISTERED NURSING**

P.O BOX 944210, SACRAMENTO, CA 94244-2100

TDD (916) 322-1700

TELEPHONE (916) 322-3350

www.rn.ca.gov

**VERIFICATION OF LICENSE**

1. Send this form to the State Board of Nursing where you have a current and active license. The board of nursing may require a processing fee. If you are licensed in a state that is a member of the Nursys verification system, use the enclosed Nursys License Verification Request Form. (The form lists states participating in Nursys.)
2. **INTERNATIONAL GRADUATES:** Send form to the state of current license. If you took the examination in a different state, make a copy of this form and send the form to that state also.

PART I: To be completed by APPLICANT and forwarded to appropriate licensing boards.					
Name: (Last, First, Middle)				Previous Names: (Including Maiden)	
Current Street Address of Record:		City:		State:	Zip Code:
Name as it Appeared on Original License: (Last, First, Middle)		Date of Birth: (Month/Day/Year)		Social Security Number:	
State of Current Licensure:	Issue Date of Current License:		Current License Number:		
State of Original Licensure:	Issue Date of Original License:		Original License Number:		
I hereby authorize all identified Boards of Nursing to release my licensure data to the California Board of Registered Nursing.					
Signature: _____				Date: _____	
PART II: To be completed by licensing board and sent to the California Board of Registered Nursing listed at the top of this form.					
This is to certify that this applicant was issued a license number to practice as a registered nurse:					
Applicant Name: _____			Date Issued: _____		
License Number: _____			Expiration Date: _____		
Licensed by: <input type="checkbox"/> Endorsement <input type="checkbox"/> Examination <input type="checkbox"/> Waiver Current Licensure Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed					
Has license ever been REVOKED, SUSPENDED, placed on PROBATION, or DISCIPLINED in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach certified documents. Reinstated? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Reinstated: _____					
Is there any PENDING disciplinary action or pending investigation against this licensee? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach information.					
Name of Professional Nursing Program:		Approved by State? <input type="checkbox"/> Yes <input type="checkbox"/> No		Graduated from: <input type="checkbox"/> High School <input type="checkbox"/> H.S. Equivalency <input type="checkbox"/> 10th Grade	
Location: (City, State/Country)		Graduation Date:		Type of Nursing Program <input type="checkbox"/> ADN <input type="checkbox"/> DIP <input type="checkbox"/> BSN <input type="checkbox"/> MSN <input type="checkbox"/> Other	
Examination Passed: <input type="checkbox"/> NCLEX-RN <input type="checkbox"/> SBTPE <input type="checkbox"/> Canadian Five-Part					
Scores: SBTPE/Canadian NCLEX-RN _____ Medical _____ Surgical _____ Obstetric _____ Pediatric _____ Psychiatric _____					Taken in English? <input type="checkbox"/> Yes <input type="checkbox"/> No Series or Exam Date: _____

Signature: _____ Title: _____

Board of Nursing: _____ Date: _____

[BOARD SEAL]